IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

LATONIA WILLIAMS, Plaintiff, v. SEDGWICK CLAIMS MANAGEMENT SERVICES, INC. AND UNITEDHEALTH GROUP INCORPORATED Defendants.	Civil Action No. 1:22-cv-570 **NOTICE OF REMOVAL**

EXHIBIT A

STATE OF NORTH CAROLINA

Guilford County

File No. 22 CVS 5539

In The General Court Of Justice
☐ District ☐ Superior Court Division

Name Of Plaintiff: Latonia Williams	**CIVIL SUMMONS**
Address: 4901 Koniwest St Apt 304	☐ ALIAS AND PLURIES SUMMONS (ASSESS FEE)
City, State, Zip: Greensboro NC 27410	G.S. 1A-1, Rules 3 and 4
VERSUS	
Name Of Defendant(s): Sedgwick	Date Original Summons Issued: ORDER GRANTED TO SUE IN FORMA PAUPERIS GUILFORD COUNTY CSC
	Date(s) Subsequent Summons(es) Issued

To Each Of The Defendant(s) Named Below:

Name And Address Of Defendant 1	Name And Address Of Defendant 2
Sedgwick 5260 Parkway Plaza Blvd Charlotte NC 28217	United HealthCare 3803 N Elm St Greensboro NC 27455

IMPORTANT! You have been sued! These papers are legal documents, DO NOT throw these papers out! You have to respond within 30 days. You may want to talk with a lawyer about your case as soon as possible, and, if needed, speak with someone who reads English and can translate these papers!

¡IMPORTANTE! ¡Se ha entablado un proceso civil en su contra! Estos papeles son documentos legales. ¡NO TIRE estos papeles!
Tiene que contestar a más tardar en 30 días. ¡Puede querer consultar con un abogado lo antes posible acerca de su caso y, de ser necesario, hablar con alguien que lea inglés y que pueda traducir estos documentos!

A Civil Action Has Been Commenced Against You!

You are notified to appear and answer the complaint of the plaintiff as follows:

1. Serve a copy of your written answer to the complaint upon the plaintiff or plaintiff's attorney within thirty (30) days after you have been served. You may serve your answer by delivering a copy to the plaintiff or by mailing it to the plaintiff's last known address, and
2. File the original of the written answer with the Clerk of Superior Court of the county named above.

If you fail to answer the complaint, the plaintiff will apply to the Court for the relief demanded in the complaint.

Name And Address Of Plaintiff's Attorney (if none, Address Of Plaintiff)	Date Issued: 6/14/22	Time: 2:24 ☐ AM ☐ PM
	Signature: [signature]	
	☐ Deputy CSC ☐ Assistant CSC ☐ Clerk Of Superior Court	

☐ ENDORSEMENT (ASSESS FEE)
This Summons was originally issued on the date indicated above and returned not served. At the request of the plaintiff, the time within which this Summons must be served is extended sixty (60) days.

Date Of Endorsement	Time ☐ AM ☐ PM
Signature	
☐ Deputy CSC ☐ Assistant CSC ☐ Clerk Of Superior Court	

NOTE TO PARTIES: *Many counties have **MANDATORY ARBITRATION** programs in which most cases where the amount in controversy is $25,000 or less are heard by an arbitrator before a trial. The parties will be notified if this case is assigned for mandatory arbitration, and, if so, what procedure is to be followed.*

(Over)

AOC-CV-100, Rev. 4/18

Original

Registered Mail Number # 22 CV 5534

THIS IS A LEGAL MATTER BETWEEN THE PARTIES NOTICE TO AGENT IS NOTICE TO PRINCIPAL-NOTICE TO PRINCIPLE IS NOTICE TO AGENT, AGENT AND EMPLOYER.

TO: LIBELEE/S ALL, INDIVIDUALLY AND SEVERALLY

SEDGEWICK

5260 PARKWAY PLAZA BLVD

CHARLOTTE NC, 28217

UNITED HEALTH GROUP

3803 N ELM ST

GREENSBORO NC, 27455

NOTICE: THIS DOCUMENT IS NOT INTENDED TO THREATEN, HARASS, HINDER OR OBSTRUCT ANY LAWFUL OPERATIONS. IT IS FOR THE PURPOSES OF OBTAINING LAWFUL REMEDY AS IS PROVIDED BY LAW.

THE FOLLOWING DOCUMENT IS AN LEGAL COURT PROCEDURE. THIS DOCUMENT IS TENDERED FOR THE PURPOSE OF REMEDY AND RELIEF OF THE ACTIONS THAT YOU HAVE TAKEN AGAINST MY DISIBILITY DISCRIMINATION RIGHTS. SEDGE WICK HEAD QUATER AND THERE THIRD PARTY UNITED HEALTH CARE GROUP WHICH IS WHO I EMPLOYED WITH & IT'S PRINCIPALS NOR IT AGENTS TOOK THE APPROPRIATE STEPS TO HELP ME WITH MY SHORT TERM DISIABILITY CASE IN REGARDS TO CONTINUING MY SHORT TERM DISABILITY WITH DOCTORS RECOMMENDATION AND LEAVE OF MY ABSENSE FROM WORK. ALSO I WAS NEVER INFORM THAT SEDGEWICK & UNITED HEALTH CARE CAN DISREGARD A LAW WHICH IS A DISABLILITY DISCRIMINATION ACT S.933 WHICH CAUSED ME TO GO BACK INTO A DEEP DEPRESSION WHICH I WAS DIAGNOSED

YEARS AGO AND IT'S BEEN IN ON GOING BATTLE AND THIS WORSEN MY CONDITIONS

AFFIDAVIT OF TRUTH

I LATONIA WILLIAMS IS IN EMPLOYER OF UNITED HEALTH CARE GROUP WAS HIRED 11/01/2021. I WAS IN HIGH RISK PATIENT AT DUKE PRENATAL IN DURHAM NC. I WAS PUT OUT OF WORK ON SHORT TERM DISABILITY WITH SEDGEWICK ON OR AROUND ABOUT 02/18/2022 AND DISABILITY WAS UP INTO 04/15/2022 WITH RE-ASSESMENT. I THEN BEGIN TO GET TREATED FOR THE SAME CONDITIONS THAT NEVER CHANGED AND THE CASE WORKER TIA L FROM SEDGE WICK DENIED MY LEAVE WITH MEDICAL PAPERWORK TO KEEP ME OUT BY MY DOCTOR JESSIE J MATHEWS AT DUKE PRIMARY CARE IN MEBANE NC BECAUSE OF MY CONTINUED PAIN 05/26/2022. I GOT REFFERED TO A SPECIALIST WHO EVAULATED ME ON 05/26/2022 FOR IN EMERGENCY APPOINTMENT ON 05/27/2022 WHO FILLED OUT THE ADDITIONAL PAPER WORK THAT THEY WAS REQUESTING AND I APPEALED IT. I THEN SPOKE TO A CUSTOMER SERVICE REPRESENTATIVE FROM BOTH PARTIES SEDGEWICK AND UNITED HEALTHCARE TODAY AT 06/10/2022 ASK TO SPEAK TO A HIGHER LEVEL FROM BOTH PARTIES THEY GAVE ME THE RUN AROUND SAYING THAT NO ONE CAN TAKE MY CALL. SEDGE WICK REPRESENATIVE ALSO TOLD ME THAT THE CLAIM WAS DENIED FOR SHORT TERM DISABILITY TODAY 06/10/2022 WHEN I ASK WHY SHE CLAIM THE PAPER WORK WASN'T SUFFICIENT ENOUGH .EVERY SINCE I BEEN DEALING WITH THIS ISSUE FROM PAYMENT BEING SHORTED AND NO CONTINUE PAYMENTS THEY BEEN GIVING ME THE RUN AROUND THEY TRIED TO SAY THEY CALLED ME. I EVEN PULLED MY PHONE RECORDS AND ONCE AGAIN NO ONE HAS CALLED ME. NUMEROUS OF TIMES I CALLED THEY NEVER BOTHERED TO RETRIEVE PAYMENTS TO ME. I JUST HAD A PREMIE BABY THAT WAS IN ICU FIGHTING FOR THERE LIFE AND BEEN DEALING WITH HIM AND TRYING TO RECOVER AND HEAL MYSELF FROM THE SURGERY I HAD TO HAVE. IF I KNEW THIS COMPANY SEDGEWICK AND IT THIRD PARTY UNITED HEALTH CARE WAS LIKE THIS I WOULD NEVER HAVE LETTING

THEM TAKE MONEY OUT MY CHECK FOR SHORT TERM DISABILITY OR EVEN WORKED FOR THE COMPANY ITSELF. I WANT TO RAISE AWARENESS TO EVERYONE WHO COULD BE GOING THROUGH THIS. I TOOK THE APPROPRIATE STEPS IN CONTACTING THE US DEPARTMENT OF LABOR AND SPOKE WITH A NICK ENG AND HIS SUPERVISOR CEASER SANTIAGO THEY SAID THEY COULDN'T FORCE THE RULES TO MAKE THEM PAY OUT BUT COULD ASK FOR THEM TO SEND PAPERS IN REGARDS TO THE STATUS NEVER RECIEVED A STATUS FROM MY APPEAL OR ANYTHING YET. IN REGARDS TO THIS NOTHING WAS DONE ON HIS END AND I ALSO CONTACTED THE NCDOI AND SPOKE WITH A JACQUIE BUTTLES SHE STATED THERE NOT IN INSURANCE REGULATED COMPANY AND THAT WHY SHE COULDN'T PICK THIS CASE UP BECAUSE IT'S A 3RD PARTY THROUGH UNITED HEALTH CARE WHO HIRED THEM TO HANDLE THERE DISABILITY CASES. SINCE THIS THERE 3RD PARTY I WANT TO SUE UNITED HEALTH CARE AS WELL BECAUSE THEY PLAY A BIG PART IN THIS THE FIRST TIME MY DISABILITY WAS DENIED SUPERVISOR MIA CLARK CALLED ME STATING THAT THIS WILL PUT MY STATUS AT RETURN TO WORK. I TOLD HER MY DOCTOR WROTE FOR ME TO BE OUT AND THEY CANNOT FORCE NO ONE TO COME BACK WITH MY MEDICAL CONDITIONS BEING THE WAY THAT IT IS BECAUSE THEY DENIED MY LEAVE WHICH SHOULD HAVE NEVER GOT DENIED IN THE FIRST PLACE WITH DOCTORS NOTES KEEPING ME OUT AND FURTHER REFFERALS TO SPECALIST INCLUDING PYSICAL THERAPY AND PSYCHIATRIST. THESE COMPANYS HAS NO SHAME OF WHAT PEOPLE GO THROUGH IN LIFE WITH THERE DISABILITIES AND THEY DON'T HONOR THERE SHORT TERM DISABILITY NOR THE DISABILITY ADA LAW. THIS THREATEN MY HOME AND LIVING ARRANGEMENTS WITH MY BABY, THIS THREATING MY TRANSPORTATION AND GAS GETTING HIM BACK IN FOURTH TO HIS DOCTORS APPOINTMENTS WHICH IS CRITICAL TO HIS HEALTH AND WITH HIM BEING A PREMIE BABY THAT CAME 3 MONTHS EARLY WITH UNDERLYING CONDITIONS. THIS THREATING ME MENTALLY, PHYSICALLY, AND EMOTIONALLY AS WELL. I ALSO WANT TO OPEN UP A CLASS ACTION LAWSUIT AGAINST THIS COMPANY FOR OTHERS WHO'S BEEN THROUGH THIS SAME THING. I'M ALSO TAKE APPROPRIATE ACTION TO SPEAK TO DISTRICT KATHY MANNING, AND THE CONGRESS IF I NEED TO GO FURTHER IN THIS I WILL ALSO BE SETTING UP IN INTERVIEW WITH ALL THE NEWS CHANNELS INCLUDING CNN.

JUSTICE TO CURE

IN JUSTICE OF VIOLATING ME DURING MY DISABILITY LEAVE AND DISABILITY ADA ACT I'M SEEKING 4 MILLION USD DOLLARS FROM SEDGEWICK WHO NOT ONLY PLAYED APART OF MY MENTAL HEALTH WHILE I WAS DEPRESSED WITH MY PAIN AND ALSO HAVING TO SEE MY SON FIGHT FOR HIS LIFE IN ICU. THEY ALSO PLAYED APART OF ME BEING EVICTED FROM MY LIVING SITUATION DUE TO THEM NOT PAYING MY SHORT TERM DISABILITY OUT SO I CAN TAKE CARE OF MY RENT PUTIING ME IN SITUATIONS WHERE I HAD TO GO INTO SURVIVAL MODE THAT VIOLATES MY LEASE. THE FOLLOWING MONTH BECAUSE THEY PRO LONG ON PAYING ME AND I HAD NO OTHER AVENUS TO TURN TO AND THE ODDS WAS AGAINST ME FOR A DESPERATE MOTHER THAT DOSENT KNOW WHAT TO DO BUT TO SURVIVE FOR HER AND HER CHILD. THEY CHEATED ME OUT OF MY MONEY I WAS PAYING TO THEM AND DISHONOR THERE OBLIGATIONS TO FURTHER PAY OUT. I WENT INTO A DEEPER MENTAL DEPRESSION AND NOW HAVE TO SEEK A PHYSICIATRIC & THERAPIST IN REGARDS TO THIS. I WANT TO ALSO SEEK JUSTICE WITH UNITED HEALTH CARE BEING I CALLED THEM MULTIPLE OF TIMES IN REGARDS TO THERE 3RD PARTY ALSO HAVE RECORED CONVERSATIONS ON BOTH PARTIES AND NOTHING WAS EVER DONE I'M SEEK 4 MILLION USD DOLLARS FROM THEM AS WELL. BECAUSE THEY ALLOWED SEDGWICK TO HANDLE THERE DISABILITY CLAIMS AND THEN CALL ME AND THREATEN ME SAYING THAT MY JOB IS AT RISK BECAUSE OF THEM DENYING THE LEAVE THEY DID NOT TAKE THE APPROPIATE STEPS TO ASK ME TO SEND IN MEDICAL DOCUMENTAION TO THEM OR MEDICAL RECORDS OF MY HEALTH AND WELL BEING THEY VIOLATED DISABILITY AS WELL.

COUNTER CLAIM

THE FOLLOWING DAMAGES HAVE BEEN ASSESSED AGAINST SEDGEWICK AND UNITED HEALTH CARE

FOR **PUNATIVE** DAMAGES I AM DEMANDING **FOUR MILLION USD DOLLARS (4,000,000.00)** FROM **SEDGEWICK COMPANY HEAD QUATERS AND FOUR MILLION USD DOLLARS (4,000,000.00) FROM UNITED HEALTH CARE HEAD QUATERS.** FOR ACTIONS THEY HAVE TAKING AGAINST ME DURING MY DISABLILITY LEAVE, AND THE DISABILITY ACT LAW .

Attention Appeals

22 CVS 5538

DISABILITY AND LEAVE
HEALTH CARE PROVIDER STATEMENT

FILED

2022 JUN 14 P 2:18

GUILFORD CO., C.S.C.

BY

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Patient Date of Birth: 08/12/1988
Claim Number: 4A22020HMA2-0001

To Be Completed by Health Care Provider (Please Type or Print)
Section 1: Required information to support FMLA/State Leave

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ✓Yes
   If yes, provide the beginning and ending dates for the period of incapacity: 5/27/2022 - 6/27/2022 * will reassess at this time
2. Has the patient recovered sufficiently to return to work? ✓No ___Yes
   If "Yes", give the date the patient was able to return to work ____/____/____
   If "No", in your opinion when, may work be resumed? (Please do not use "indefinite", "unknown", "undetermined", etc.) If a date cannot be determined, please estimate in days, weeks or months.___/___/___
3. Has the patient recovered sufficiently to return to restricted work? ✓No ___Yes
   If "Yes", indicate date restrictions begin: ____/____/____ Date restrictions end: ____/____/____
   Restriction (s) required: _____
4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ✓Yes
   If yes, dates of admission: admitted 2/7/2022 - delivered 2/8/2022 - d/c on 2/11/2022 * no hosp since
5. Date(s) you treated the patient for condition: 5/27/2022
6. Was medication, other than over-the-counter medication prescribed? ___No ✓Yes
7. Is the medical condition pregnancy? ✓No ___Yes If yes, expected delivery date: _____
8. Is the patient unable to perform any of his/her job functions due to their condition: ___No ✓Yes
   If yes, identify the job functions the employee is unable to perform (use the list of the employee's essential functions or job description, if included, or answer this question based upon the patient's own description of his/her job functions)
9. Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment).
   DO NOT INCLUDE DIAGNOSIS IF PATIENT IS IN CA OR CT:
   pelvic pain in female; dyspareunia; pelvic floor dysfunction; recent pregnancy s/p classical c/s on 2/8/22.

C3121015S.340-2573

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Claim Number: 4A22020HMA2-0001

Section 2: Required information to support Disability Benefits

10. Objective findings: HT: 5'3" WT: 194lbs BP: 118/83 TEMP: — PULSE: 87 RESP: 16
11. Patient's Complaints: abdominal pain
12. Your Diagnosis: (list all disabling diagnoses including all ICD10 codes)
    Primary: ICD10 Code: R10.2 Description: pelvic pain in female.
    Secondary: ICD10 Code: N94.10 Description: dyspareunia, female
    ICD10 Code: M62.89 Description: pelvic floor dysfunction
13. List all co-morbid conditions: postpartum depression; hx of cervlage s/p removal; hx of c-section (classical)
14. Describe objective/clinical findings to warrant disability, including severity and duration based on the patient's presentation during office visits. high pelvic floor muscle tone; pelvic floor muscle tenderness, bilateral lower abdomen tenderness
15. When was patient first diagnosed with this condition? 5/27/2022
16. When is the patient's next office visit? 06/14/2022 with PT
17. Have there been any Emergency Room visits OR Hospitalizations during this current disability period? ___No ___Yes
    If Yes: ____ Emergency Room visit ____ Hospitalization ____ 23-hour admission
    Name and address of hospital or facility: _____
18. List all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
Flexeril	10mg	BID prn		Yes ☒ No ☐	Yes ☐ No ☐	5/27/2022
				Yes ☐ No ☐	Yes ☐ No ☐	___/___/___
				Yes ☐ No ☐	Yes ☐ No ☐	___/___/___
				Yes ☐ No ☐	Yes ☐ No ☐	___/___/___

19. Is this condition the result of an injury? X No ___Yes Is this condition work related? X No ___Yes
    If yes, provide date and description of event:
20. If patient is pregnant, is a C-Section planned? X No ___Yes If yes, date scheduled? ____/____/____
21. What is the prescribed treatment plan? (please provide specific details regarding treatment/therapy, attach notes if necessary):
    Referral to pelvic floor physical therapy; flexeril prn; heat prn; flu in 3 months & pelvic ultrasound to evaluate for any other etiologies for her pain.

C312101155.340-2573

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Claim Number: 4A22020HMA2-0001

22. Has any surgical procedure related to current disability been performed or is any anticipated? ___No _X_ Yes
List the name of the procedure: hx of c-section w/ adhesiolysis surgical removal on 2/8/2022
CPT code: _____ Date of procedure: 02/08/2022

23. Has patient been referred to other physician(s)/specialist? ___No _X_ Yes If yes, provide physician name, specialty, and telephone number. pelvic floor PT (919) 684-2445

24. List specific functional limitations of Activities of Daily Living (ADL's): _____

25. Has patient been given any driving restrictions for this disability period? _X_ No ___Yes
If yes, please describe: _____

Attach all office notes, History & Physical, results of x-rays, laboratory tests, MRI Reports, etc., if relevant.
"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Health Care Provider Information (Required):

Telephone Number: (919)997-3000
Fax Number: (919)997-3001
Date Completed: 5/31/2022
Physician/Provider Printed Name: Sara Wilson, PA-C
Physician/Provider Specialty: OBGYN
Physician/Provider Signature: S Wilson PA-C
Physician/Provider NPI: 1255957595

C3121015S.340-2573

Appeal Form

Claim Number: 4A22020HMA2-0001	Employee ID Number: 001765053	
Last Name: Williams	First Name: Latonia	Middle Initial: A
Best Contact Phone Number: 336-801-2437	Alternate Phone Number: 336-338-9696	

To appeal the denial of your benefits, please complete this form and return it within **180 days** from your receipt of your original denial letter, with the information requested in the checklist below. If your appeal is not received within **180 days** the original denial will be upheld.

Appeal Checklist (please complete and submit the following):

☐ **Explain the reason for your appeal request.** (Attach a separate document if additional space is needed.)

I was never supose to been denied from the start because my medical condition are still the same & needs to continue care with my provider & medications. Supporting documents will be attached

☐ **Update all of your treating provider name(s), phone number(s) and specialty below:** (Attach a separate document if additional space is needed to list all treating provider and contact information.)

Provider Name: Sara James Wilson PA	Phone Number: 919-684-2441 Specialty: Ortho Surgical Dept
Provider Name: Mark Herville PT, DPT	Phone Number: 919-684-2441 Specialty: PT, DPT

☐ **Attach all information, which has not been previously submitted and you want reviewed for appeal, including but not limited to:**

- **Medical information from your treating provider(s) that documents and shows how your condition prevents you from doing the essential functions of your job.**
  - ✓ **Written documentation from your provider(s) of their observation(s) and finding(s) from your examination(s) and/or treatment(s)**
  - ✓ **Office visit note(s) from each provider(s) providing care during the denied time of your absence**
  - ✓ **Lab report(s), radiology report(s), or report(s) of other diagnostic studies**
  - ✓ **Therapy note(s), and/or any behavioral health assessment(s)**
- **Any other documentation which may support your claim for disability benefits**

☐ **Sign the below certification:**

I hereby certify that the information provided is complete and accurate to the best of my knowledge.

Employee Signature: Latonia Williams Date: 05-31-2022

Please include additional pages if you need to include information with this request that does not fit on this form.

Please mail completed form to:

National Appeals Unit (NAU)
PO Box 14446
Lexington, KY 40512-4446
Telephone: 866-697-8122 Fax: (888) 488-9536

C312101155-340-2573

Attention Appeals

DISABILITY AND LEAVE
HEALTH CARE PROVIDER STATEMENT

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Patient Date of Birth: 08/12/1988
Claim Number: 4A22020HMA2-0001

To Be Completed by Health Care Provider (Please Type or Print)
Section 1: Required information to support FMLA/State Leave

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ✓Yes
   If yes, provide the beginning and ending dates for the period of incapacity: 5/27/2022 8/27/2022 * will reassess at this time
2. Has the patient recovered sufficiently to return to work? ✓No ___Yes
   If "Yes", give the date the patient was able to return to work ____/____/____
   If "No", in your opinion when, may work be resumed? (Please do not use "indefinite", "unknown", "undetermined", etc.) If a date cannot be determined, please estimate in days, weeks or months.___/___/___
3. Has the patient recovered sufficiently to return to restricted work? ✓No ___Yes
   If "Yes", indicate date restrictions begin: ____/____/____ Date restrictions end: ____/____/____
   Restriction (s) required: _____
4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ✓Yes
   If yes, dates of admission: admitted 2/7/2022 - delivered 2/8/2022 - d/c on 2/11/2022 * no hosp since
5. Date(s) you treated the patient for condition: 5/27/2022
6. Was medication, other than over-the-counter medication prescribed? ___No ✓Yes
7. Is the medical condition pregnancy? ✓No ___Yes If yes, expected delivery date: _____
8. Is the patient unable to perform any of his/her job functions due to their condition: ___No ✓Yes
   If yes, identify the job functions the employee is unable to perform (use the list of the employee's essential functions or job description, if included, or answer this question based upon the patient's own description of his/her job functions)
9. Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment).
   DO NOT INCLUDE DIAGNOSIS IF PATIENT IS IN CA OR CT:
   pelvic pain in female; dyspareunia; pelvic floor dysfunction; recent pregnancy s/p classical c/s on 2/8/22.

C312101555.340-2573

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Claim Number: 4A22020HMA2-0001

Section 2: Required information to support Disability Benefits

10. Objective findings: HT: 5'3" WT: 194lbs BP: 118/83 TEMP: — PULSE: 87 RESP: 16

11. Patient's Complaints: abdominal pain

12. Your Diagnosis: (list all disabling diagnoses including all ICD10 codes)

Primary: ICD10 Code: R10.2 Description: pelvic pain in female.

Secondary: ICD10 Code: N94.10 Description: dyspareunia, female

ICD10 Code: M62.89 Description: Pelvic floor dysfunction

13. List all co-morbid conditions: postpartum depression; hx of cerclage s/p removal; hx of c-section classic

14. Describe objective/clinical findings to warrant disability, including severity and duration based on the patient's presentation during office visits. high pelvic floor muscle tone; pelvic floor muscle tenderness, bilateral lower abdomen tenderness

15. When was patient first diagnosed with this condition? 5/27/2022

16. When is the patient's next office visit? 06/14/2022 with PT

17. Have there been any Emergency Room visits OR Hospitalizations during this current disability period? ___No ___Yes

If Yes: ___ Emergency Room visit ___ Hospitalization ___ 23-hour admission

Name and address of hospital or facility: _____

18. List all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
Flexeril	10mg	BID prn		Yes ☒ No ☐	Yes ☐ No ☐	5/27/2022
				Yes ☐ No ☐	Yes ☐ No ☐	___/___/___
				Yes ☐ No ☐	Yes ☐ No ☐	___/___/___
				Yes ☐ No ☐	Yes ☐ No ☐	___/___/___

19. Is this condition the result of an injury? X No ___Yes Is this condition work related? X No ___Yes

If yes, provide date and description of event:

20. If patient is pregnant, is a C-Section planned? X No ___Yes If yes, date scheduled? ___/___/___

21. What is the prescribed treatment plan? (please provide specific details regarding treatment/therapy, attach notes if necessary):

Referral to pelvic floor physical therapy; flexeril prn; heat prn; flu in 3 months & pelvic ultrasound to evaluate for any other etiologies for her pain.

C312101555-340-2573

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Claim Number: 4A22020HMA2-0001

22. Has any surgical procedure related to current disability been performed or is any anticipated? ___No X Yes
List the name of the procedure: hx of classical cesarean c/s, cerclage removal on 2/8/2022
CPT code: _____ Date of procedure: 02/08/2022

23. Has patient been referred to other physician(s)/specialist? ___No X Yes If yes, provide physician name, specialty, and telephone number. pelvic floor PT (919) 684-2445

24. List specific functional limitations of Activities of Daily Living (ADL's): _____

25. Has patient been given any driving restrictions for this disability period? X No ___Yes
If yes, please describe: _____

Attach all office notes, History & Physical, results of x-rays, laboratory tests, MRI Reports, etc., if relevant.
"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Health Care Provider Information (Required):

Telephone Number: (919)997-3000
Fax Number: (919)997-3001
Date Completed: 5/31/2022
Physician/Provider Printed Name: Sara Wilson, PA-C
Physician/Provider Specialty: OBGYN
Physician/Provider Signature: S Wilson PA-C
Physician/Provider NPI: 1255857595

C3121015S-340-2573

DISABILITY AND LEAVE
HEALTHCARE PROVIDER STATEMENT

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Patient Date of Birth: 08/12/1988
Claim Number: 4A22020HMA2-0001

To Be Completed by Healthcare Provider (Please Type or Print)
Section 1: Required information to support FMLA/State Leave

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ✓Yes
   If yes, provide the beginning and ending dates for the period of incapacity: 02/07/22 - 04/15/22 * will be reassessed
   * Please see attached notes
2. Has the patient recovered sufficiently to return to work? ✓No ___Yes
   If "Yes", give the date the patient was able to return to work ___/___/___
   If "No", in your opinion when, may work be resumed? (Please do not use "indefinite", "unknown", "undetermined", etc.) If a date cannot be determined, please estimate in days, weeks or months. 4/15/22
3. Has the patient recovered sufficiently to return to restricted work? ✓No ___Yes
   If "Yes", indicate date restrictions begin: ___/___/___ Date restrictions end: ___/___/___
   Restriction (s) required:
4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ✓Yes
   If yes, dates of admission: admitted on 02.07.22 ~ discharge on 02.11.22
5. Date(s) you treated the patient for condition: 10.07.21 ~ present
6. Was medication, other than over-the-counter medication prescribed? ___No ✓Yes
7. Is the medical condition pregnancy? ___No ✓Yes If yes, expected delivery date: Actual Delivery Date: 02.08.22
8. Is the patient unable to perform any of his/her job functions due to their condition: ___No ✓Yes
   If yes, identify the job functions the employee is unable to perform (use the list of the employee's essential functions or job description, if included, or answer this question based upon the patient's own description of his/her job functions)
   Employee is unable to perform all job duties while on maternity leave
9. Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment).
   DO NOT INCLUDE DIAGNOSIS IF PATIENT IS IN CA OR CT:
   Medical leave for Cesarean delivery is 8 weeks. Employee may take more time pending employer approval. She may not drive for 2 weeks post delivery or while on any narcotics. Patient will have a 4-6 week postpartum follow up appointment pending no complications.

C31210155.340-2573

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Claim Number: 4A22020HMA2-0001

22. Has any surgical procedure related to current disability been performed or is any anticipated? ___No ___Yes
List the name of the procedure: Cesarean Delivery
CPT code: 59514 Date of procedure: 02/08/22

23. Has patient been referred to other physician(s)/specialist? ✓No ___Yes If yes, provide physician name, specialty, and telephone number. —

24. List specific functional limitations of Activities of Daily Living (ADL's): She may not drive for 2 weeks post delivery or while on any narcotics. She will need assistance with self-feed new born infant care.

25. Has patient been given any driving restrictions for this disability period? ___No ✓Yes
If yes please describe: She may not drive for 2 weeks post delivery or while on any narcotics

Attach all office notes, History & Physical, results of x-rays, laboratory tests, MRI Reports, etc., if relevant.
"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Healthcare Provider Information (Required):

Option #2 then #2

Telephone Number: 919.684.6327 Physician/Provider Printed Name: Duke Perinatal Durham
Fax Number: 919.681.1397 Physician/Provider Specialty: Maternal Fetal Medicine
Date Completed: 2.24.22 Physician/Provider Signature: [signature]
Physician/Provider NPI: 56-102.9437

C312101555-340-2573

Return to UnitedHealth Group Disability and Leave Service Center
Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568 | Phone: 866-697-8122

Patient Name: Latonia A. Williams
Claim Number: 4A22020HMA2-0001

Section 2: Required information to support Disability Benefits

10. Objective findings: HT: 162cm WT: 208 BP: 104/72 TEMP: 37.4 °C PULSE: 93 RESP: 17
11. Patient's Complaints: Cesarean Delivery of Infant
12. Your Diagnosis: (list all disabling diagnoses including all ICD10 codes)
    Primary: ICD10 Code: Cervical incompetence Description: 287.42
    Secondary: ICD10 Code: 20 weeks gestation Description: 23 A.24
    ICD10 Code: Classical Cesarean Section Description: 082
13. List all co-morbid conditions: Cesarean Delivery
14. Describe objective/clinical findings to warrant disability, including severity and duration based on the patient's presentation during office visits. Cesarean Delivery w/ 8 Weeks post delivery pending no complications.
15. When was patient first diagnosed with this condition? 08/04/2021
16. When is the patient's next office visit? 03/10/2022
17. Have there been any Emergency Room visits OR Hospitalizations during this current disability period? ✓ No ___ Yes
    If Yes: ___ Emergency Room visit ___ Hospitalization ___ 23 hour admission
    Name and address of hospital or facility: —
18. List all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
		NA		Yes ☐ No ☐	Yes ☐ No ☐	__/__/__
				Yes ☐ No ☐	Yes ☐ No ☐	__/__/__
				Yes ☐ No ☐	Yes ☐ No ☐	__/__/__
				Yes ☐ No ☐	Yes ☐ No ☐	__/__/__

19. Is this condition the result of an injury? ✓ No ___ Yes Is this condition work related? ✓ No ___ Yes
    If yes, provide date and description of event:
20. If patient is pregnant, is a C-Section planned? ___ No ✓ Yes If yes, date scheduled? 02/08/2022
21. What is the prescribed treatment plan? (please provide specific details regarding treatment/therapy, attach notes if necessary):
    Will require one time 4-6 weeks postpartum follow up appointment pending no complications.

C3121015S-340-2573

DukeHealth

Duke Primary Care Mebane
1352 MEBANE OAKS ROAD
MEBANE NC 27302-9681
Phone: 919-563-8400
Fax: 919-304-2393

April 26, 2022

Patient: **Latonia Williams**
Date of Birth: **8/12/1988**
Date of Visit: **4/26/2022**

To Whom it May Concern:

Latonia Williams was seen in my clinic on 4/26/2022. She is currently under our care at the time and is needing evaluation by specialists. Unsure of a day for her to come back at this time. We will continue to re-evaluate. Please excuse her absence. The patient is receiving appropriate medical therapy for her condition.

If you have any questions or concerns, please don't hesitate to call.

Sincerely,

JESSNIE JOSE-MATHEWS, MD

Your EAP and WorkLife Services Benefit

Life can present challenges that require you to be away from work. During these times, free, confidential help is available.

Employee Assistance Program (EAP) and WorkLife Services provide **free** confidential support for those challenges. It's available around the clock anytime you need it. This benefit offers assistance and support for all these concerns and more:

- Anxiety
- Child and elder care
- Emotional problems
- Financial issues
- Grief, depression and stress issues
- Living with chronic conditions
- Parenting and family issues
- Relationship problems
- Substance abuse
- Workplace conflicts

From short-term counseling services (five **free** sessions) and referrals to more extended care, your EAP and WorkLife Services Benefit offers just what you need.

How Does It Work?
Accessing your EAP and WorkLife Services Benefit is easy and available 24 hours a day. Simply call **toll-free** 1-866-781-6396. A specialist will help you identify the nature of your problem and the appropriate resources to address it.

Connecting Online
For 24-hour, confidential access to your EAP benefits, visit liveandworkwell.com. You can check benefit information, submit requests for services, search the directory of clinicians, access information and resources for hundreds of issues, and participate in interactive, customizable self-improvement programs. Any member of your household has access to these online services, including dependents living away from home.

How Much Will This Benefit Cost?
There is no charge for referrals, seeing a clinician within the network, initial consultation with financial and legal experts, or mediators. Subsequent legal assistance is available at a 25 percent discount. Access to liveandworkwell.com is always free.

Are Services Confidential?
Your personal records are not shared with anyone without your permission. All records, including medical information, referrals and evaluations, are kept strictly confidential in accordance with federal and state laws. In an emergency, the first concern is your health. Call 911 or get to an emergency room as soon as possible.

Call toll-free 1-866-781-6396
www.liveandworkwell.com

APPROVAL

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Phone: 866-697-8122 | Web: https://claimlookup.com/uhg. **| Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568**

March 30, 2022

Dear Latonia Williams:

You are approved for your time away from work.

Short-Term Disability Benefits

- **Your Claim Number:** 4A22020HMA2-0001
- **Waiting Period Dates:** February 18, 2022 through February 24, 2022.
- **STD Approved Dates:** February 25, 2022 through May 03, 2022
- **Reduction in Payment Amount:** Your benefit payment may be reduced by other sources of income such as state disability benefits, and social security disability. If you are receiving any other income, you must provide proof of the amount in the form of an award letter, pay stub or other documentation.

Unpaid Leave of Absence Determination

- **UnitedHealth Group Medical Leave Approved Dates:** February 18, 2022 through May 3, 2022 = 10.60 weeks. This will be counted against your UnitedHealth Group Medical Leave entitlement given there are no changes to your leave.

Here's What You Need to Do:

If You Are Able to Return to Work

- ☐ Notify your manager to make plans for your return to work and to discuss options available to you.
- ☐ On your first day back, notify the United Health Group Disability and Leave Service Center of your return to work by phone at 866-697-8122 or https://claimlookup.com/uhg. Also, provide your schedule for the week of your return if it differs from the schedule reported when you filed your claim.
- ☐ **Provide us with any return-to-work information:**
  - If you are released to return to work with restrictions; or
  - When you physically return to work, up to 5 days prior to your return to work date.

If You Need Additional Time Away from Work

- ☐ If you are not able to return to work as planned or you need more time away from work, contact the United Health Group Disability and Leave Service Center and your healthcare provider to request and obtain updated medical documentation.
- ☐ We will need updated medical documentation by **May 16, 2022** to be able to extend your time away from work and pay. You are responsible for any fees your healthcare provider may charge for medical documentation.

How to Return Your Documents:

Upload: https://claimlookup.com/uhg **| Email:** uhgdisabilityandleave@sedgwick.com **| Fax: 866-697-8149**

Need Additional Help?

You can access your claim information 24/7 at https://claimlookup.com/uhg or by calling UnitedHealth Group Disability and Leave Service Center at 866-697-8122. If you have any questions, UnitedHealth Group Disability and Leave Service Center representatives are available Monday through Friday between 7:00AM and & 7:00PM Central Time.

DISABILITY APPEAL PROCEDURES

How to Request an Appeal
If you disagree with the denial decision; you may request an appeal (an independent review of your claim). You or your representative have 180 days from when you received notice of denial to submit a written request for appeal at the following address:

National Appeal Unit (NAU)
PO Box 14446
Lexington, KY 40512-4446
Fax: (888) 488-9536

Enclosed is an Appeal Form to request a review of your denied disability claim. You are not required to use this Appeal Form and may instead submit your own written request.

You shall be provided, upon written request and free of charge, reasonable access to, and copies of, all documents, records, internal rules, guidelines, protocol and other information relevant to your claim for benefits.

Information to consider when requesting an appeal:

- Is there new medical documentation to submit with your appeal?
- Does the new medical documentation cover the timeframe that has been denied?
- Has medical documentation been submitted from all of your treating providers?

During the appeal process you will be given the opportunity to receive and review the relevant documents pertaining to your claim, and submit any additional information you feel is pertinent.

Review and Appeal Process
The National Appeals Unit will consider all documents, records and other information submitted, even if this information was not previously provided. The person conducting the review will not be the same person who made the initial decision, nor a subordinate of that individual.

If the denial was based on medical information, the National Appeals Unit will consult with a health care professional who has appropriate training in the field of medicine that is relevant to your condition. This person will be independent and impartial. They will not be the same person who was consulted during the initial evaluation of your claim nor a subordinate of a person that was consulted. The National Appeal Unit will ask the health care professional to contact your treating provider(s) to discuss and/or obtain any additional medical information that may be pertinent to your appeal.

If you need additional time to provide medical records, documentation or other information, "tolling" may be available upon request. Tolling (additional time) will temporarily pause for a 45 day decision period while you provide additional information.

Notice of the Review Decision
The National Appeals Unit will provide the appeal decision within 45 days after receipt of the request for appeal. You will receive a notice of this decision in writing. If an extension is required, you will receive a notice explaining why the extension is needed and the new decision date.

Legal Action
You have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, if your claim for benefits is denied after there has been full exhaustion of your appeal rights under the Plan. You must bring a lawsuit for benefits no later than 3 years after the final decision on your claim under these claim procedures.

Appeal Form

Claim Number: 4A22020HMA2-0001	Employee ID Number: 001765053	
Last Name: Williams	First Name: Latonia	Middle Initial: A
Best Contact Phone Number: 336-801-2437	Alternate Phone Number: 336-338-9696	

To appeal the denial of your benefits, please complete this form and return it within **180 days** from your receipt of your original denial letter, with the information requested in the checklist below. If your appeal is not received within **180 days** the original denial will be upheld.

Appeal Checklist (please complete and submit the following):

☐ **Explain the reason for your appeal request.** (Attach a separate document if additional space is needed.)

I was never suppose to been denied from the start because my medical conditions are still the same & need to make Calls with my providers & medications. Supporting documents will be attached

☐ **Update all of your treating provider name(s), phone number(s) and specialty below:** (Attach a separate document if additional space is needed to list all treating provider and contact information.)

Provider Name: Sara James Wilson PA	Phone Number: 919-684-2471 Specialty: Orthopedic Surgery
Provider Name: Matt Harville PT, DPT	Phone Number: 919-684-2446 Specialty: PT, DPT

☐ **Attach all information, which has not been previously submitted and you want reviewed for appeal, including but not limited to:**

- **Medical information from your treating provider(s) that documents and shows how your condition prevents you from doing the essential functions of your job.**
  - ✓ **Written documentation from your provider(s) of their observation(s) and finding(s) from your examination(s) and/or treatment(s)**
  - ✓ **Office visit note(s) from each provider(s) providing care during the denied time of your absence**
  - ✓ **Lab report(s), radiology report(s), or report(s) of other diagnostic studies**
  - ✓ **Therapy note(s), and/or any behavioral health assessment(s)**
- **Any other documentation which may support your claim for disability benefits**

☐ **Sign the below certification:**

I hereby certify that the information provided is complete and accurate to the best of my knowledge.

Employee Signature: Latonia Williams Date: 05-31-2022

Please include additional pages if you need to include information with this request that does not fit on this form.

Please mail completed form to:

National Appeals Unit (NAU)
PO Box 14446
Lexington, KY 40512-4446
Telephone: 866-697-8122 Fax: (888) 488-9536

C312101555-340-2573

5/23/2022 4A22020HMA20001 562022052330587

FedEx Office

4215 W Wendover Ave Ste F & G
Greensboro, NC 27407-1921
(336) 316-1165

Terminal: 1095MIX01
6/2/2022 19:22
Receipt #: 1095C7C1930
Type: Purchase

Qty	Description	Amount
2	Self Serve Scan 8.5x11/14, 11x17	0.98

SubTotal	0.98
District tax	0.00
City tax	0.00
County tax	0.02
State tax	0.05
Total	USD $1.05

Acct #:**********8672
VISA DEBIT
Chip Read
Auth No.: 981621
Mode: Issuer
AID: A0000000031010
NO CVM
CVM Result: 5F0002
TVR: 8000008000
IAD: 06011203602000
TSI: 6800
ARC: 00
APPROVED

The Cardholder agrees to pay the Issuer of the charge card in accordance with the agreement between the Issuer and the Cardholder.

FedEx Office

Tell us how we're doing and receive $5 off your next $30 print order*. Complete our survey by scanning the QR code below, visit **fedex.com/welisten**.

Offer expires 12/31/2022

*$5 off print order of $30.00 or more. Discount applies to orders placed in a FedEx Office store or online through FedEx Office® Print Online. Offer is valid at time of purchase only, no cash value and may not be discounted or credited toward past or future purchases, discount cannot be used in combination with custom-bid orders, other coupons, or discounts, including account pricing. Discount not valid on the following products and services: finishing only orders; self-service print, photo station, fax or scan; direct mail, EDDM® or postage. Does not apply to shipping, Custom Branded boxes, rush or delivery charges. Does not apply to retail products. No cash value. Offer void where prohibited or restricted by law. Products, services and hours may vary by location. © 2021 FedEx. All rights reserved. Offer expires 12/31/2022.

By submitting your project to FedEx Office or by making a purchase in a FedEx Office store, you agree to all FedEx Office terms and conditions, including limitations of liability.

Request a copy of our terms and conditions from a team member or visit **fedex.com/officeserviceterms** for details.

☐ Update all of your treating provider name(s), phone number(s), [illegible] (If additional space is needed to list all treating provider and contact information.)

Provider Name: Sara James Wilson PA	Phone Number: 919-684-2471 Specialty: OB Surgical Dept
Provider Name: Matt Harville PT, DPT	Phone Number: 919-684-2446 Specialty: PT, DPT

☐ **Attach all information, which has not been previously submitted and you want reviewed for appeal, including but not limited to:**

- **Medical information from your treating provider(s) that documents and shows how your condition prevents you from doing the essential functions of your job.**
  - ✓ **Written documentation from your provider(s) of their observation(s) and finding(s) from your examination(s) and/or treatment(s)**
  - ✓ **Office visit note(s) from each provider(s) providing care during the denied time of your absence**
  - ✓ **Lab report(s), radiology report(s), or report(s) of other diagnostic studies**
  - ✓ **Therapy note(s), and/or any behavioral health assessment(s)**
- **Any other documentation which may support your claim for disability benefits**

☐ **Sign the below certification:**

I hereby certify that the information provided is complete and accurate to the best of my knowledge.

Employee Signature: Latonia Williams Date: 05-31-2022

Please include additional pages if you need to include information with this request that does not fit on this form.

Please mail completed form to:

National Appeals Unit (NAU)
PO Box 14446
Lexington, KY 40512-4446
Telephone: 866-697-8122 Fax: (888) 488-9536

E5121013-340-2373

5/23/2022 4A22020HMA20001 562022052330587

TRANSMISSION VERIFICATION REPORT

TIME : 06/01/2022 02:19
NAME :
FAX :
TEL :
SER.# : U6331AK7J492786

DATE,TIME	06/01 02:17
FAX NO./NAME	18884889536
DURATION	00:01:41
PAGE(S)	04
RESULT	OK
MODE	STANDARD

DISABILITY DETERMINATION

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Phone: 866-697-8122 | Web: https://claimlookup.com/uhg.| Fax: 866-697-8149 | PO Box 14568, Lexington, KY 40512-4568

May 24, 2022

Dear Latonia Williams:

After review of your Short-Term Disability (STD) claim, it has been determined that you do not qualify for STD benefits under the UnitedHealth Group STD Plan beyond May 03, 2022.

We previously received medical information, which confirmed your disability through May 03, 2022. The determination to deny an extension of benefits is based on a review of the following documentation: Medical Note from provider Dr. Jessnie Jose-Mathews, dated April 26, 2022

While you indicated you were totally incapacitated, the Medical Note received on April 26, 2022 from your provider Jessnie Jose-Mathews did not provide any objective supporting information to indicate total disability. While your provider notes continued therapy is needed for your condition it is unclear how your condition disables you from performing your sedentary work from home job functions. Given that, short term disability is denied at this time.

The following contacts were made following your last approval:

On 04/26/2022, we received a note from your doctor.

On 05/03/2022, you called customer service to verify paperwork was received and received claim update.

On 05/06/2022, you called customer service to verify approval dates and receive information regarding payments.

On 05/09/2022, your examiner attempted to contact you, but the call could not be completed as dialed.

On 05/12/2022, you called customer service regarding payments.

On 05/13/2022, your examiner attempted to contact you, but the call could not be completed as dialed.

On 05/13/2022, your examiner reached out to you via email.

On 05/16/2022, a medical request was sent to provider Dr. Jessnie Jose-Mathews.

On 05/17/2022, you called customer service requesting claim updates.

On 05/18/2022, your examiner attempted to contact you, but the call could not be completed as dialed.

On 05/18/2022, a medical request was sent to provider Dr. Jessnie Jose-Mathews.

Short-Term Disability Benefits

- **Your Claim Number:** 4A22020HMA2-0001
- **Your STD Denial Dates:** May 04, 2022 through return to work
- **Your Concurrent Leave of Absence:** You will or have already received separate communication regarding any concurrent Family and Medical Leave Act (FMLA), state/local and/or company leave.

This determination is based on the following Plan provision(s):

How the STD Program Works: The STD Program may provide income protection and pay benefits when the Program Administrator determines that you are Disabled (i.e., you are unable to perform the Material Duties of

your Own Occupation because of a non-work-related Medical Condition, and you are receiving Regular and Appropriate Care from a Physician) while you are covered under the Program.

When You Are Disabled: Sedgwick determines whether or not you are Disabled as defined by the Program. You are considered Disabled when all of the following conditions are met: You have been seen face to face by a Physician about your Disability within 10 business days of the first day of absence related to the Disability leave of absence; Your physician has provided Medical Evidence that supports your inability to perform the Material Duties of your Own Occupation. (Note: Medical Evidence may be office visit notes, objective clinical findings, etc. A note from a doctor giving a date range such as "off work from x date to y date" is not Medical Evidence.); You are under the Regular and Appropriate Care of a Physician; and your Medical Condition is not work-related and is a Medically Determinable Impairment... If you file a claim because of a Mental Disorder, Regular and Appropriate Care requires that you be in Active Treatment with a Mental Health Provider (at least two times per month with a Mental Health Provider).

Appeal Rights

- You have 180 days to appeal this determination. Your appeal request must be received by November 25, 2022.
- If you disagree with this determination, provide further clarification of how your medical condition limits your ability to perform your job duties and meets your plan's definition of disability. This includes any missing medical documentation related to your disability from recent healthcare provider visits.
- Reference the enclosed insert for appeal rights and instructions.

Reasonable Accommodations

UnitedHealth Group is committed to providing reasonable accommodations to help employees with a disability perform their essential job functions. If you are an individual with a physical or mental impairment that impacts your ability to do your job, you may be eligible for a reasonable accommodation as defined under the Americans with Disabilities Act (ADA).

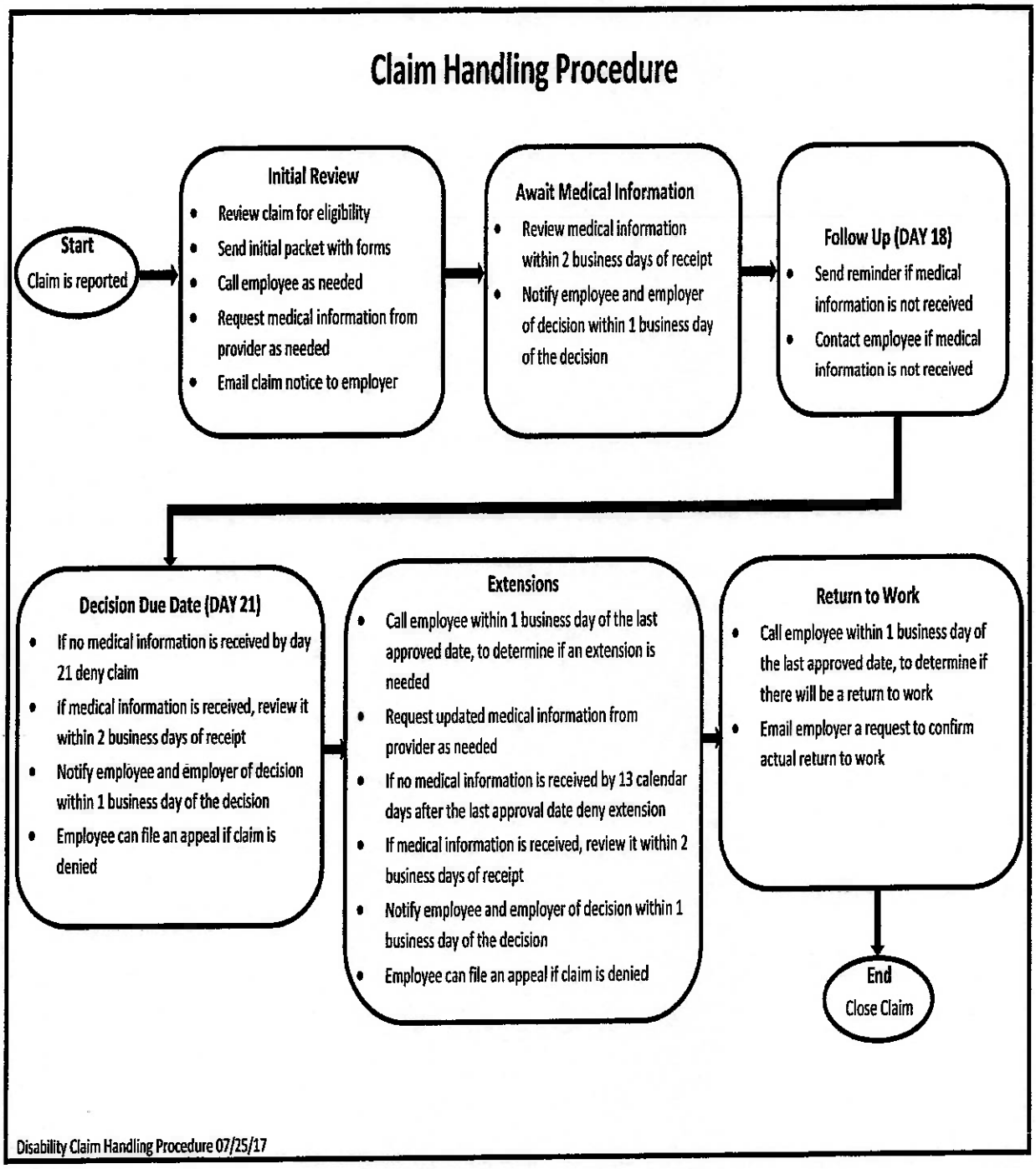
If the need for a reasonable accommodation is identified during your claim process, an ADA Accommodation request will automatically be initiated, and we will work with you and your manager to identify reasonable accommodations that would allow you to perform the essential functions of your job.

Need Additional Help?

You can access your claim information 24/7 at https://claimlookup.com/uhg or by calling UnitedHealth Group Disability and Leave Service Center at 866-697-8122. If you have any questions, UnitedHealth Group Disability and Leave Service Center representatives are available Monday through Friday between 7:00AM and & 7:00PM Central Time.

Thank you,
Tia L.
UnitedHealth Group Disability and Leave Service Center

SPANISH (Español):	Para obtener asistencia en Español, llame al [866-697-8122].
TAGALOG (Tagalog):	Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [866-697-8122].
CHINESE (中文):	如果需要中文的帮助，请拨打这个号码 [866-697-8122].
NAVAJO (Dine):	Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [866-697-8122].


Claim Handling Procedure
Start
Claim is reported
Initial Review
Review claim for eligibility
Send initial packet with forms
Call employee as needed
Request medical information from provider as needed
Email claim notice to employer
Await Medical Information
Review medical information within 2 business days of receipt
Notify employee and employer of decision within 1 business day of the decision
Follow Up (DAY 18)
Send reminder if medical information is not received
Contact employee if medical information is not received
Decision Due Date (DAY 21)
If no medical information is received by day 21 deny claim
If medical information is received, review it within 2 business days of receipt
Notify employee and employer of decision within 1 business day of the decision
Employee can file an appeal if claim is denied
Extensions
Call employee within 1 business day of the last approved date, to determine if an extension is needed
Request updated medical information from provider as needed
If no medical information is received by 13 calendar days after the last approval date deny extension
If medical information is received, review it within 2 business days of receipt
Notify employee and employer of decision within 1 business day of the decision
Employee can file an appeal if claim is denied
Return to Work
Call employee within 1 business day of the last approved date, to determine if there will be a return to work
Email employer a request to confirm actual return to work
End
Close Claim
Disability Claim Handling Procedure 07/25/17

UnitedHealth Group Disability and Leave Service Center
P.O. BOX 14568
Lexington, KY 40512-4568

sedgwick®

UNITEDHEALTH GROUP

Phone: (866) 697-8122
Fax: (866) 697-8149

May 24, 2022

Latonia A. Williams
Po Box 16554 4807 Kenview St Apt 304
Greensboro, NC 27410

5/23/2022 4A22020HMA20001 562022052330587

DukeHealth

Duke Perinatal Clinic
2608 ERWIN RD
STE 200
DURHAM NC 27705-4597
Phone: 919-684-2471
Fax: 919-681-1397

February 18, 2022

Patient: **Latonia Williams**
Date of Birth: **8/12/1988**
Date of Visit: **2/18/2022**

To Whom it May Concern:

Latonia Williams was seen in my clinic on 2/18/2022. She underwent a large surgery on 2/8. Please excuse her absence to allow for her recovery for the following dates: today through 4/15/22. At this time, we will reassess if any additional time away from work is needed. The patient is receiving appropriate medical therapy for her condition.

If you have any questions or concerns, please don't hesitate to call.

Sincerely,

ALEXANDRA CLARE SUNDERMANN, MD

DukeHealth

Duke Primary Care Mebane
1352 MEBANE OAKS ROAD
MEBANE NC 27302-9681
Phone: 919-563-8400
Fax: 919-304-2393

April 26, 2022

Patient: **Latonia Williams**
Date of Birth: **8/12/1988**
Date of Visit: **4/26/2022**

To Whom it May Concern:

Latonia Williams was seen in my clinic on 4/26/2022. She is currently under our care at the time and is needing evaluation by specialists. Unsure of a day for her to come back at this time. We will continue to re-evaluate. Please excuse her absence. The patient is receiving appropriate medical therapy for her condition.

If you have any questions or concerns, please don't hesitate to call.

Sincerely,

JESSNIE JOSE-MATHEWS, MD